North Carolina Department of Health and Human Services
Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Leza Wainwright, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Craigan L. Gray, MD, MBA, JD, Director

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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Leza Wainwright

SUBJECT: Implementation Update #65
Payment Error Rate Measurement in NC
Provider Verification & Credentialing
PCP Development by TFC Providers
Changes in SAIOP, SACOT, and ACTT
CS Case Management Component
CAP MR/DD Update
CABHA Service Array Clarification

Payment Error Rate Measurement in North Carolina

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as one of 17 states required to participate in PERM reviews of Medicaid Fee-For-Service and Medicaid Managed Care claims paid in Federal fiscal year 2010 (October 1, 2009-September 30, 2010). The PERM CHIP measurement is on hold until publication of the new final rule.

CMS is using two national contractors to measure improper payments. One of the contractors, Livanta LLC (Livanta), will be communicating directly with providers and requesting medical record documentation associated with the sampled claims. Providers will be required to furnish the records requested by Livanta, within a timeframe indicated by Livanta.

It is anticipated that Livanta will begin requesting medical records for the NC sampled claims in January, 2010. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.

Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and Federal Regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider rendering services.

Provider Verification and Credentialing Activities

Community Intervention Services (CIS) agencies have now received the re-verification packets that must be completed and returned to Computer Sciences Corporation (CSC) immediately to ensure uninterrupted enrollment as a CIS provider. For detailed information, please review Implementation Update #63 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/), the November 2009 Medicaid Bulletin (http://www.ncdhhs.gov/dma/bulletin/) or contact the CSC EVC Call Center at 1-866-844-1113.

PCP Development by Therapeutic Foster Care Providers

In response to concerns from Therapeutic Foster Care (TFC) placement agencies regarding difficulties in accessing Community Support services for the timely completion of the Person Centered Plan (PCP) for children and adolescents receiving TFC, the Department of Health and Human Services (DHHS) is announcing the following policy change: In instances where a child does not have Community Support services or another clinical home service, a qualified professional (QP) on staff with the licensed private child-placing agency (LCPA) may complete the PCP as required for submission.

The TFC QP, in addition to the six hours of "Person Centered Thinking" must also complete a required three hours of "PCP Instructional Elements" training prior to developing a PCP. See Implementation Update #10 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh7-6-06update10.pdf) and the updated PCP manual on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' (DMH/DD/SAS) website (http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/pcp/pcp_2008_instruction_manual.pdf) for more information. It is noted that there are a wide variety of very good Person Centered Thinking trainings currently available in NC. The PCP Instructional Webcast Training (http://www.ncdhhs.gov/mhddsas/pcp.htm) or other PCP planning/writing training may aid in fulfilling these requirements, as well.

This policy change is made possible by a revision to section 10A NCAC 70G .0503 PLACEMENT SERVICES for foster parents and therapeutic foster parents, effective November 1, 2009 that requires supervision of therapeutic foster parents by a qualified professional as defined in 10A NCAC 27G. 0503. Under this requirement, an LCPA will have on staff individuals qualified to assume the responsibility for completing PCPs for children in their care.

Changes in SAIOP, SACOT, and ACTT

SAIOP

Effective January 1, 2010, Medicaid recipients receiving Substance Abuse Intensive Outpatient Program (SAIOP) services may be seen for the initial 30 days of treatment without a prior authorization. Services provided after this initial 30 day "pass-through" period require authorization from the Medicaid approved vendor (Value Options). This pass-through is available only once per calendar year. For State-funded SAIOP services, local management entities (LMEs) will establish authorization guidelines in accordance with the local consumer benefit plan to ensure rapid access to needed treatment.

Any requests for authorization to ValueOptions for these services must entail the total units, including the unmanaged units and the start date of the admission to assure accurate transfer of information to HP/EDS for claims adjudication.

SACOT

Effective January 1, 2010, Medicaid recipients receiving Substance Abuse Comprehensive Outpatient Treatment (SACOT) services may be seen for the initial 60 days of treatment without a prior authorization. Services

provided after this initial 60 day "pass-through" period require authorization from the Medicaid approved vendor (Value Options). This pass-through is available only once per calendar year. For State-funded SACOT services, LMEs will establish authorization guidelines in accordance with the local consumer benefit plan to ensure rapid access to needed treatment.

Any requests for authorization to ValueOptions for these services must entail the total units, including the unmanaged units and the start date of the admission to assure accurate transfer of information to HP/EDS for claims adjudication.

ACTT

Effective January 1, 2010, providers of Assertive Community Treatment Team (ACTT) services have the option of offering a midsize ACT Team consisting of between 51 and 75 recipients. Currently, providers of ACTT services may provide treatment via a small team (up to 50 recipients) or via a large team (51-100 recipients). With the effective date of January 1, 2010, providers will have the option of staffing for the midsize team and providing services for between 51 and 75 recipients. The following paragraphs describe the staffing criteria for all three levels available within the ACTT service definition (large, mid-size, and small). Effective January 1, 2010, these changes become effective in the ACTT service definition. The entire service definition will be updated to reflect these as well as other changes at a future date.

- The ACT fidelity model is based on the use of a large team consisting of 10-12 staff to serve 100 recipients. For a community with only 75 recipients requiring ACT services, the mid-size team consisting of 8-10 staff may be used and a community of at least 50 recipients requiring ACT services may use the small team consisting of 6-8 staff.

- Large ACT Team: serving 76-100 recipients consists of 10-12 staff (in addition to the psychiatrist and program assistant). Team composition is as follows:
  - 1 full-time master's-level qualified professional team leader
  - 2 FTE registered nurses (RNs)
  - 1 FTE substance abuse specialist (LCAS, CCS, or CSAC)
  - 1 FTE qualified professional in mental health (preferably with a master's degree in rehabilitation counseling) with responsibility for role as vocational specialist
  - 2 FTE master's-level qualified professionals in mental health or substance abuse
  - 1 FTE certified peer support specialist (may be filled by no more than two individuals)
  - 2 FTE qualified professionals or associate professionals in mental health or substance abuse
  - 32 hrs per week psychiatrist
  - 1 full-time program assistant
  - Additional positions are based on the needs of the individuals served; additional staff members shall meet at least qualified professional, associate professional or paraprofessional status.

- Mid-size ACT Team: serving 51-75 recipients consists of 8-10 staff (in addition to the psychiatrist and program assistant). Team composition is as follows:
  - 1 full-time master's-level qualified professional team leader
  - 2 FTE registered nurses (RNs)
  - 1 FTE substance abuse specialist (LCAS, CCS, or CSAC)
  - 1 FTE qualified professional in mental health (preferably with a master's degree in rehabilitation counseling) with responsibility for role as vocational specialist
  - 2 FTE master's-level qualified professionals in mental health or substance abuse
  - 1 FTE certified peer support specialist (may be filled by no more than two individuals)
  - 32 hrs per week psychiatrist
  - 1 full-time program assistant
  - Additional positions are based on the needs of the individuals served; additional staff members shall meet at least qualified professional, associate professional or paraprofessional status.

- Small ACT Team: serving at least 50 recipients consists of 6-8 staff (in addition to the psychiatrist and program assistant). Team composition is as follows:
  - 1 full-time master's-level qualified professional team leader
  - 1 FTE registered nurse (RN)
  - 1 FTE substance abuse specialist (LCAS, CCS, or CSAC)
  - 1 FTE qualified professional in mental health (preferably with a master's degree in rehabilitation counseling) with responsibility for role as vocational specialist
  - 1 FTE master's-level qualified professional in mental health or substance abuse
  - 1 FTE certified peer support specialist (may be filled by no more than two individuals)
  - 16 hrs per week psychiatrist
  - 1 full-time program assistant
  - Additional positions are based on the needs of the individuals served; additional staff members shall meet at least qualified professional, associate professional or paraprofessional status.

Please refer to the ACTT service definition for detailed description of the roles and responsibilities of each of the above staff.

Community Support Case Management Component

The Centers for Medicare and Medicaid Services has approved our request to continue the case management component of Community Support service by qualified and licensed professionals during the interim period until the new case management service definition is approved. As a result, consumers currently receiving Community Support and new consumers entering the system on or after January 1, 2010 will be able to receive the case management component of Community Support in order to ease the transition to the new case management service under the following conditions: [Note: LMEs may also authorize the case management component of CSS for non-Medicaid eligible consumers under these same criteria, subject to availability of funds and the provisions of the LME's benefit plan.]

- Recipients currently receiving CSS would continue to receive all appropriate Community Support service components until the end of the current authorization period. At the end of the current authorization, if additional case management services are medically necessary, the provider may request to continue the case management component of CSS by a qualified or licensed professional.
- Providers may request the case management component of Community Support for new recipients who meet medical necessity on or after January 1, 2010.
- Only qualified and licensed professionals may provide the case management component of CSS.
- All concurrent (reauthorizations) and new authorizations as of January 1, 2010, for the case management component of CSS shall be based upon medical necessity and shall not exceed four hours per month.
- The Inpatient Treatment Report (ITR) and PCP submitted to ValueOptions should support the need for the case management component of CSS and should include case management specific goals and interventions. The other service components of CSS (e.g. therapeutic, psychoeducation, and skill based interventions) will not be authorized and any goals related to those interventions should be removed from the plan.
- Providers are expected to comply with all the requirements of the CSS service definition as found in Clinical Coverage Policy 8A with the exception of the provision of therapeutic, psychoeducational, and skill based interventions of CSS.
- The case management component of CSS may not be provided with any other enhanced service.

For all concurrent (reauthorizations) and new authorizations as of January 1, 2010, the following case management functions of CSS are the only service components that may be provided.

- Coordination and oversight of initial and ongoing assessment activities.
- Identification of strengths that will aid the individual in his or her recovery, as well as the identification of barriers that impede the development of skills necessary for independent functioning in the community.
- Facilitation of the Person Centered Planning process which includes the active involvement of the recipient and people identified as important in the recipient's life (e.g., family, friends, and providers).

- Initial development and ongoing revision of the Person Centered Plan.
- Ensuring linkage to the most clinically appropriate and effective services.
- Coordination of clinical services, natural and community supports for the recipient and his or her family, including coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care.
- Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the consumer, and natural and community supports.
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan.
- Provide direct interventions in situations that are escalating to prevent crisis, based on identification of cues and triggers.

Requests for Community Support services for children must follow the established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) procedures and requirements, which are available at http://www.dhhs.state.nc.us/dma/epsdt.

Enhanced Service Providers and Requests to ValueOptions.

IU #60 provided a list of enhanced services that could not be authorized in conjunction with CSS. Those treatment providers are responsible for the development of the PCP, including the Crisis Plan, submission of the consumer admission form to the LME, and submission of the applicable request for authorization form and supporting documentation to ValueOptions. These providers are also responsible for referring the recipient to other appropriate services if a request for authorization is denied.

CAP-MR/DD Update

CAP-MR/DD Re-Endorsement Letter of Attestation
In Implementation Update #62 the CAP-MR/DD Re-Endorsement Letter of Attestation includes *Day Services* as a CAP-MR/DD service requiring re-endorsement. *Day Services* should not have been included in the list of CAP-MR/DD services requiring CAP-MR/DD re-endorsement since it is not a CAP-MR/DD service. Please do not check the *Day Services* block when completing the form. *Day Services* will be removed from the form letter if/when the CAP-MR/DD Re-Endorsement Letter of Attestation is revised.

National Accreditation
This serves as a reminder of the requirement for national accreditation for providers of CAP-MR/DD waiver services. As required by General Statue 122C-81, providers of waiver services (with the exception of the Adult Day Health service which does not require national accreditation) shall have achieved national accreditation by November 1, 2009. The law establishes specific benchmarks by which specific activities related to accreditation must be completed by providers. The LMEs are responsible for monitoring providers to ensure providers are meeting the benchmarks and have secured accreditation by the November 1, 2009 deadline. If providers do not meet all established benchmarks including the November 1, 2009 deadline the LME must remove the provider's endorsement and notify the Division of Medical Assistance. The law requires DHHS to terminate the provider's enrollment in the Medicaid program within 60 days of the provider's failure to meet the required benchmarks. There are no allowable exceptions to this law. For further information see Implementation Update # 47.

Allocation of Additional CAP-MR/DD Slots
The Division of Mental Health, Developmental Disabilities and Substance Abuse Services provided formal notification to the LMEs on November 19, 2009 regarding the release of CAP-MR/DD slots. This notification can be found at the following link: http://www.ncdhhs.gov/mhddsas/announce/additionalcap-mrddslots11-09.pdf

Critical Access Behavioral Health Care Agency (CABHA)
Implementation Update #63 and #64 defines the service array as part of the core requirements to be eligible for certification as a Critical Access Behavioral Health Care Agency (CABHA). In the list of additional services Child Residential Level II, III, and IV are identified. Please note that Level II refers to both Program type and

Family type (Therapeutic Foster Care). However, providing multiple residential services (i.e. Level II and Level III) will only count toward one of the additional services (thus, why they are listed together). In other words, if an agency provides Level II and Level III, they would still need to provide an additional non-residential service, such as Intensive In-Home in order to meet the requirement of two additional services that create a continuum of care for the age/disability served.

Providers who wish to pursue the CABHA certification but do not yet meet the minimum requirements may electronically submit a letter of intent signed by the CEO of the agency to the LME Systems Performance Team at Contact.DMH.LME@dhhs.nc.gov. Letters of attestation will be accepted beginning December 1, 2009.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
Allen Feezor
Michael Watson
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Jennifer Hoffmann
Shawn Parker
Melanie Bush
John Dervin
Kari Barsness